AMERICAN INTELLIGENCE.

ORIGINAL COMMUNICATIONS.

Radical Cure following an Operation for the Relief of Strangulated direct Inguinal Hernia. By SAMUEL J. JONES, M. D., Assistant Surgeon U. S. N.—C. D., a sailor attached to a gunboat on the blockade, on the 12th of March, attempted to raise a navy gun-carriage supporting a 100-ponnder Parrott gun. On the following day, March 13, he complained to the medical officer of the vessel, Act.-Assist. Surgeon Henry, of having pain in his "stomach." An anodyne was given him, and no further complaint was made by him until about 1 o'clock A. M. on the morning of the 14th, when he complained of pain in his groin, and some swelling. Examination revealed inguinal hernia of the right side. An effort to reduce it by taxis was made, which proved unavailing. An enema of infusion of tobacco was given, and the effort to reduce by taxis was repeated, but without success. At 7 A. M., a nauseant was given him, and during the relaxation from that, another trial was made to reduce it by taxis, which also failed. At 11 A. M., on the same day, I was asked to see the patient, and to operate to relieve the strangulation. After learning the history of the case, we concluded to etherize the patient thoroughly, and apply ice to the base of the tumour, and make one more effort by taxis before operating. This, too, failed to produce the desired result, and at 3 o'clock P. M.—about 48 hours after the hernia was produced—whilst the patient was again under the influence of ether, I cut down upon the tumour, under the impression that it was indirect inguinal hernia, which had become strangulated at the external abdominal ring. As soon as I opened the sac, I found that there was no constriction at the external ring, nor was there any portion of the intestine in the inguinal canal. A portion of the intestine, about the size of a small hen's egg, rested on the spermatic cord, outside of the external ring. It was almost black, and was immovable at the point of constriction, which proved to be in the conjoined tendon, on the inner side of the internal column of the external ring. With difficulty I succeeded in getting a blunt-pointed bistoury upon the point of constriction, which was small, and not unlike the stem of a mushroom, beneath the larger crown. By careful and constant pressure I succeeded in getting the bistoury introduced through the stricture. Then, by slightly rotating the bistoury, I enlarged the artificial opening in the conjoined tendon, and drew out the bowel a little distance, and soon had the gratification of seeing the blackened hue of the bowel replaced by more of a mahogany colour, showing that the circulation was being re-established in the part. After waiting a few moments for this purpose, I again introduced the knife, and enlarged the opening sufficiently to enable me to return the bowel to the cavity of the abdomen, which I did by carefully kneading it. As soon as the bowel was replaced, the incision was closed by a few sutures and adhesive strips, and covered with a compress and roller. At 10 P. M., the patient took an anodyne, and rested well during the night. On the morning of the 15th

his pulse was 80, and full and strong. A saline aperient was given him, and arrowroot diet. Later in the day, there was slight arterial excitement, and his bowels had not been relieved. His pulse was controlled by small repeated doses of tartar emetic, and enemata of warm water were administered, followed by fecal discharge.

On the 16th he was doing well, and was transferred to the U. S. Naval Hospital at Portsmouth, Va.

Subsequently, I learned from Surgeon Wales, U. S. Navy, who attended him whilst there, that, after several days in the hospital, decided peritonitis followed, which yielded to opiates and general antiphlogistic treatment.

His recovery was delayed by repeated imprudence in his diet during his convalescence, but he eventually recovered, and it seems the cure is radical.

Fracture of the Thigh by a Minie Ball. By ARMISTEAD PETER, M. D., Ass. Surg. U. S. A., Seminary Hospital, Georgetown, D. C. (Extract from a letter to the editor, dated June 11, 1863.)

My attention has been called to an article in your journal of April, 1863, by Dr. Carothers, on fracture of femur, and in justice to myself and associates I must take upon myself to correct Dr. C.'s views concerning the case which he saw at the Seminary Hospital.

Lieut. Joseph Tall, 86th N. Y. volunteers, was wounded in the seven days' fight, Pope's campaign. Having laid in an old barn for *ten days*, he was brought to our hospital September 9th, and placed in my ward. Upon examination I discovered a fracture of the right femur, about two inches *below the trochanters*, and not extending *into* the trochanters (also another wound immediately below the left clavicle, the ball making its exit above the left scapula; this wound healed kindly, and gave but little inconvenience). The fractured femur was immediately placed in one of Professor Smith's anterior splints, and the leg suspended. Although a man of indomitable pluck, he was very weak when I first saw him. My patient for two weeks did remarkably well, when he complained of pain at the fracture. I assisted Surg. B. A. Clements, U. S. A., when he readjusted the splint, which had become slightly displaced; pain was relieved, and the patient did well for several days, when symptoms of pyemia set in. Under judicious treatment the pyemia subsided, and he was once more cheerful, *when unfortunately the adhesive strips which supported the splint and leg became displaced, very little, it is true, but still enough to move the upper suspending* cord *above* the point of fracture. *This caused* the upper fragment to become depressed, whilst the lower one was raised in proportion; the consequence was that apposition was wanted, and the rough serrated edges of the two bones being brought in contact with the muscles, intense irritation ensued. Sunday, 28th September, I discovered the cause of complaint, and reported the circumstances to the surgeon in charge, F. Hinkle, late of the U. S. N. We immediately concluded to etherize the patient and make a thorough examination, which we did, and found but one piece of bone separated from the shaft, and that was *perfectly square*, about *an inch* (*not more*) in diameter. This was removed. We found the fracture to be oblique, and the edges roughly serrated. The leg was very painful at this time. Dr. H. and myself expressed our opinion freely about amputating and exsecting, but concluded to wait until the next day, Monday, September 29th, when Surgeon Clements (who had charge of all the hospitals here) would see the case again. Lieut. Tall was perfectly satisfied to have his leg amputated, and so expressed himself. Dr. Clements exa-